Systemic Organizational Change for the Collaborative Care Approach to Managing Depressive Disorders

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The U.S. Preventive Services Task Force recommends screening for depression in adults[1] and adolescents[2] in outpatient primary care settings when adequate systems are in place for efficient diagnosis, treatment, and follow-up of depressive disorders. The Prevention Practice Committee of the American College of Preventive Medicine subsequently suggested that all primary care settings should have such systems in place, given the prevalence and associated morbidity of depressive disorders.[3] In addition to facilitating routine screening and establishing the diagnosis, the collaborative care model, discussed in articles in this issue of the *American Journal of Preventive Medicine*,[4–6] is designed to increase primary care providers' use of evidence-based protocols in managing depressive disorders and to improve clinical and community support for patients' active engagement in shared decision making and self-management. (Of note, I use the term *patient* herein for clarity and concision, although modern conceptions of recovery,[7,8] which emphasize shared decision making and empowerment, rightly prefer terms like *consumer*, *mental health service user*, or *client*.)

As discussed in the articles from the Community Preventive Services Task Force (Task Force; with collaborators from other institutions, agencies, and associations) in this issue of the Journal,[4–6] the adoption of an integrated, collaborative care model for the management of depressive disorders is a method of establishing adequate systems to ensure diagnosis, treatment, and follow-up of depressive disorders.[4] Collaborative care models typically employ case managers to liaise among primary care providers, patients, and mental health professionals. Depressive disorders are highly prevalent, and most patients with such disorders who are in treatment are seen in primary care settings (emphasis is added here to acknowledge the vast problem of lack of treatment and inadequate treatment,[9,10] and the need for other efforts to enhance initial care-seeking). Team-based, integrated care processes within these primary care settings (collaborative care approaches) allow for mental health professionals to provide clinical advice and decision support to primary care providers and case managers.

The Task Force now lays out unequivocal recommendations for the use of collaborative care in managing depressive disorders.[4] In addition to a smaller but favorable effect on health-related quality of life and functional status, and a significant effect on satisfaction with care (which was a secondary outcome), Thota and colleagues[5] give convincing evidence of robust effectiveness of collaborative care on the primary outcomes of improvements in depressive symptoms, medication and/or psychotherapy treatment adherence, response to treatment, and remission of and recovery from symptoms. In my view, effectiveness in these outcome domains provides ample justification for disseminating and promoting the integrated, collaborative care approach to treating depressive disorders in primary care settings. After all, the humanitarian argument (reducing suffering) for preventive efforts is sufficient aside from arguments on economic grounds.[11] Nonetheless, there is also evidence that the collaborative care approach provides good economic value (i.e., it is cost effective), documented by Jacob and colleagues,[6] which is especially important given that decisions around population-based health interventions are intimately linked to economic, aside from humanitarian, considerations.

Unlike many recommendations for the management of specific diseases and disorders, the integrated, collaborative care approach to depressive disorders is a healthcare system–level intervention that requires organizational change. That is, healthcare organizations will have to commit infrastructural and human resources (for the added elements of coordination and case management) to reap the benefits of this approach. Thus, collaborative care is more complex to implement and disseminate relative to the use of specific pharmaceuticals, somatic interventions, or periodic screenings. Into the mix of organizational considerations that will undoubtedly be the focus of efforts to implement the collaborative care ap-

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proach, I will mention three organizational-change issues that are deserving of attention, each of which could conceivably further advance collaborative care, although research in these areas (as well as logistical planning and evaluation of reimbursement) will be necessary.

First, the potential utility of telepsychiatry in the context of the collaborative care model should be considered. One of the greatest barriers to the implementation of the collaborative care approach is likely a relative lack of availability of psychiatrists and other licensed mental health specialists; this is particularly true in rural and remote areas. Thus, discussions of implementing and disseminating the collaborative care approach must include considerations of using telemedicine/telepsychiatry.[12,13] As noted by the authors,[4] collaborative, integrated care processes often rely heavily on technology (e.g., electronic medical records, telephone contact, and provider-reminder mechanisms), making this approach also conducive to the use of telepsychiatry. Might live, interactive videoconferencing technology facilitate the collaborative care approach in rural and remote areas, and improve efficiency in settings where one of the key ingredients of the model (specialty mental health consultants) is lacking in terms of proximity? Acceptability (among patients and mental health specialists) and feasibility of telepsychiatry in collaborative care should be studied in rural and remote settings that might otherwise have difficulty implementing collaborative care.

Second, the possibility that peer specialists could augment the collaborative care model is worth addressing. Nurses served as case managers in most studies reviewed by Thota and colleagues,[5] and the authors indicated that in their subgroup analyses to examine effects of potential moderators, when social workers or master's-level mental health workers (commonly recent graduates with limited past clinical experience) assumed the case manager role, intervention effects were smaller, which may reflect a need for additional skill development and clinical experience. Given that the case manager role is the crucial linchpin in the integrated, collaborative care approach, additional research is needed on this team member's necessary training, experience, and responsibilities.

More work is needed in examining the potential role of peer specialists—individuals with lived experience with a mental illness who have successfully engaged in recovery and work as allied mental health workers[14,15]—as the case manager or as an additional member of the collaborative care team. I fully agree with the authors[5] that "care should be taken by organizations wishing to implement collaborative care to ensure that training is adequate for individuals assuming these roles" (and that additional research in this area is needed), and I would add that the potential role of peer specialists should be examined. Might the use of peer specialists improve patient acceptability and enhance cost effectiveness and clinical effectiveness? Indeed, some of the roles of the case manager, such as support for self-care, might best be provided by peers with lived experience.

Third, having an option for home-based treatment might add value. As suggested by the authors,[5] while the collaborative care approach has been shown to be effective in a range of settings that span outpatient and inpatient care, limited evidence exists on such models in community settings. Indeed, only two included studies in the review by Thota and colleagues involved home-based care (both focusing on older adults),[16,17] although effects from those studies were similar to the overall estimate. Might a community-based, rather than a clinic-based, collaborative care approach further enhance efficiency, effectiveness, and/or satisfaction with care? For example, potential barriers to implementation like patient reluctance to enroll and low patient appointment attendance could be overcome with a community-based (i.e., home-based) approach. Home-based collaborative care might be especially beneficial to patients with comorbidities that make clinic attendance difficult.

As professionals from this field, we know that currently available psychopharmacologic and psychotherapeutic treatments for depressive disorders are effective. The rigorous work of Thota and colleagues[5] and Jacob et al.[6]—and that of the studies they reviewed, meta-analyzed, and synthesized—now provide convincing evidence that collaborative care for depressive disorders is an effective and cost-effective framework for delivering those treatments. Being population-based interventions that organize, coordinate, and oversee team members and team processes, and ensure quality (i.e., concordance with evidence-based guidelines), health systems are obligated, in my opinion, to provide treatments for depressive disorders using the collaborative care approach.

On a concluding note, just as mental health and primary care should partner to implement and widely disseminate the collaborative care model, so too should mental health and public health engage in closer partnerships to design, implement, and evaluate preventive interventions for depressive disorders.[18] So, *collaboration* is likely the key to success in both the treatment and the prevention of high-prevalence and high-morbidity depressive disorders.

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